BRITISH COLUMBIA
Ministry of Health Services

REPORT ON HEALTH AUTHORITY PERFORMANCE AGREEMENTS 2002/03

MINISTRY OF HEALTH SERVICES
MINISTRY OF HEALTH PLANNING
BRITISH COLUMBIA

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INTRODUCTION

With the creation of six new health authorities in December 2001, government laid the foundation for an integrated, accountable health services system that responds to patient needs within a fiscally sustainable framework.

By delegating responsibility for local health services (such as home and hospital care) to five regional health authorities and responsibility for provincial and specialized health services (such as cancer care) to a single provincial health authority, government made a significant shift from the piecemeal approach of managing health services through 52 diverse regional entities with often competing or overlapping mandates.

Together, the six new health authorities not only have comprehensive responsibility for the governance and management of the majority of health services delivered in British Columbia (BC); they have clear accountability for the impact of their decisions on patients and patient outcomes.

In April 2002, inaugural Performance Agreements, signed between the health authorities and the Ministry of Health Services, reflected this new responsibility and articulated expectations for health authority performance – individually and collectively – over the three-year period from 2002/03 to 2004/05.

Reflecting the overall direction provided in the Ministry of Health Services and Ministry of Health Planning Service Plans for the same time period (which can be viewed at www.gov.bc.ca), the Performance Agreements detail key areas for improvement, including ensuring patients have access to emergency services within a standard time frame, developing services and programs to allow seniors and clients with chronic illnesses (like diabetes or congestive heart failure) to be as independent as possible for as long as possible and focusing on disease and illness prevention by encouraging people to make healthy life-style choices.

Report on 2002/03 Health Authority Performance Agreements is an initial report on the progress made by health authorities, in their first year, as they strive to meet the Performance Agreement expectations within the context of the larger Service Plan goals and objectives.

In this first year of more open and accountable reporting, the need for coordinated and timely data collection has been recognized. The Ministries of Health are actively working with health authorities and statistical agencies, such as the Canadian Institute for Health Information (CIHI), to ensure required data are available in a timely way to assist both decision-making and results reporting activities.

The BC government has made a strong commitment to clear and transparent performance reporting in the health sector. As the Ministries of Health and the new health authorities gain experience with their new roles and relationships, performance measurement setting, monitoring, and reporting processes will evolve and become more refined.

BACKGROUND

Health authorities are responsible for managing and delivering most publicly funded health services to the people of BC, with the exception of the majority of physician services, some allied health professional services (such as physiotherapy), Pharmacare, and ambulance services. Although outside the direct scope of health authorities, these services are heavily dependent on the support of health authorities through hospitals and laboratories.

A patient-centred health system means patients are able to have their care needs met seamlessly as they move through the system. An important role of the Ministry of Health Services is to facilitate this kind of integration and coordination between service partners and providers. In turn, health authorities, in their performance and planning activities, must consider the impact of their decisions not just on the services they provide directly, but on the health system as a whole.

In their first year of operation, health authorities were expected to develop plans for redesigning their hospital and community-based health programs and to begin delivering on activities to improve the ability of these programs to meet patient needs in a fiscally sustainable manner.

When developing their redesign plans, health authorities were expected to consider a range of trends that reflect changing technologies and procedures in health care, as well as changes in the way people want to be treated and providers want to practice. These trends indicate that:

- BC's population, while ageing, is staying healthier later in life.
- Seniors and other home and community care patients want options that allow them to stay in their own homes and be independent as long as possible.
- Reliance on hospital inpatient beds has declined over the past 30 years as more procedures and treatments are offered in out-patient or office settings.
- Integrated and coordinated care across facilities and in the community avoids unnecessary admissions to hospital and proper management of chronic diseases.
- A strong emphasis on prevention of ill-health, whether through water quality improvements, infection control or encouraging healthy lifestyle choices, has a measurable impact on the health of a population and the cost of health care.

Health authorities were provided with certain guidelines and standards to frame their redesign work. For example, in February 2002, the Ministry published *Standards of Accessibility and Guidelines for Provisions of Sustainable Acute Care Services* to ensure appropriate patient access to emergency services, hospitals, and other specialty services in all areas of the province is protected.

PERFORMANCE MONITORING & MEASUREMENT

To guide activity in BC's publicly funded health care sector, the provincial government established three overarching goals for the health system:

1. High-quality, patient-centred care.
2. Improved health and wellness for British Columbians.
3. A sustainable, affordable public health system.

At a health authority level, these goals translate into priorities for change, including:

- more efficient use of acute care services, including a coherent and planned approach to the provision of emergency and surgical services;
- switching from residential care to community care to reflect changing needs and expectations of home and community care clients;
- increasing the emphasis on the continuity of care for mental health clients;
- focusing on public health and prevention services; and
- improving financial performance.

The Ministries' annual Service Plans and health authority Performance Agreements[1] are two of the primary vehicles being used to establish baseline measurements and targets for improved performance in the health sector. The Ministries' Annual Service Plan Reports and Report on Health Authority Performance Agreements are the primary vehicle for reporting on the progress made on achieving those targets.

The *Report on 2002/03 Health Authority Performance Agreements* is organized to reflect the Performance Agreement structure and to provide comment on health authority activity aimed at meeting the performance targets set for five priority areas for improvement, namely:

- Acute Care (including Emergency Health and Surgical and Procedural Services)
- Mental Health Services
- Home and Community Care
- Public/Population Health
- Support and Administrative Services

[1] In May 2003, the BC Auditor General released an independent review of the province's first-ever Performance Agreements. Although he acknowledged "putting these agreements in place is a significant step towards strengthening the performance of the BC health care system," he called for greater clarity and collaboration in the development of future agreements, particularly with regards to establishing performance measures. This report is for 2002/03, the fiscal year prior to the release of the Auditor General's review, and in turn does not reflect this recent actions undertaken by the Ministries and health authorities to implement the Auditor General's recommendations.

The *Report* is an opportunity to compare the performance of health authorities relative to each other, Ministry expectations, and to provide the public with ongoing information on the impact of redesign on patient services. Because PHSA does not have geographic boundaries like other health authorities and provides specialized provincial services, the comparison of their operations with other health authorities is often not possible or appropriate.

Where possible, and to provide a clear understanding of the linkages between activities at both the Ministries and health authority level, the Performance Agreement expectations have been linked to relevant Service Plan goals and strategies.

ACUTE CARE REDESIGN

Service Plan Goal:
- High-quality, patient-centred care.

Health Authority Related Service Plan Strategy:
- Rationalize and redesign acute care services.

Performance Agreement Expectations:
- Develop guidelines for best practices in the management of emergency health care.
- Develop measures of the performance of surgical and procedural services in the province's hospitals.

Long-term trends in Acute Care in BC match those seen in other parts of Canada and the rest of the developed world. Use of hospital inpatient beds has been decreasing for about 30 years as new technologies and practices evolve. The causes of this trend , which is consistent over time regardless of funding levels , are multiple and include:

- use of more sophisticated equipment, technologies, and pharmaceuticals for quicker diagnoses and more effective treatment;
- more diverse care in outpatient and office settings, such as day surgeries and drug therapies;
- focus on shorter length of stays, based on research showing shorter stays result in quicker recoveries;
- the desire of patients to recover at home and be functioning independently as much as possible; and
- the provision of community-based services to provide patient support at home.

In BC, this downward trend in hospital bed use has resulted in a reduced need for beds overall, in spite of high population growth levels in the 1980s and 1990s. Based on these trends, health authorities have been tasked with determining hospital inpatient program need, location, and configuration in the years ahead.

EMERGENCY HEALTH SERVICES

Health authorities were expected to collaborate with the Ministries of Health and other health authorities in developing guidelines to better manage demands on the emergency health services in the acute hospital system. Within the process directed and supported by the Provincial Health Services Authority (PHSA), the expected product during 2002/03 was a set of guidelines for best practices in the management of emergency health care, including reporting requirements, measures, and assessments of service coordination.

Similarly, health authorities were required to develop measures to report the responsiveness of the health system and acute care hospitals to meeting emergency and elective surgical and procedural needs. This included reaching an agreement on the principles to be used by health authorities in classifying cases as emergent or urgent/elective, plus a methodology and a plan for measuring the appropriateness and outcomes of selected procedures.

In 2002/03, the PHSA established the *Emergency Services Steering Committee*, which initiated short-term and long-term task groups[2]. The short-term task group was directed to identify and prioritize emergency services problems in urban and rural areas and to recommend solutions that could be implemented within 12 months. An *Emergency Services Short-term Task Group Progress Report*, released in April 2003 (and available at www.phsa.ca), identified opportunities to improve access, utilization, and the effectiveness of emergency services. Each health authority is now working to meet the progress report recommendations.

[2] The long-term task group began work in May 2003. With broad representation from practitioners, health authority staff, community, primary care, and chronic disease groups, its mandate is to create a strategic plan for long-term reform, improvement, and ongoing evaluation of the emergency services system. To allow time for this consultation, findings from the group are now expected at the end of the 2003/04 fiscal year.

SURGICAL AND PROCEDURAL SERVICES

Health authorities were also expected to collaborate with the Ministries of Health and each other in developing measures of the performance of surgical and procedural services in the province's hospitals, within the process directed and supported by the PHSA.

In 2002/03, expected products were:

- to develop measures of the response of the health care system to emergency surgical and procedural needs;
- to reach an agreement on the principles to be used by health authorities in classifying cases as emergent or urgent/elective;
- to create a plan to measure the appropriateness and outcomes of selected procedures; and
- to adopt these outputs/standards.

In February 2003, the PHSA established the *Provincial Surgical and Procedural Services Committee* to guide this initiative. The late start on this activity is due, in part, to the extensive involvement of other jurisdictions outside BC and a comprehensive approach to ensuring participation by all parts of the province through such tools as teleconferencing. The committee's work is informed by surgical reviews and related regional health authority planning activities (underway or complete). Surgical reviews and health authority activities include:

INTERIOR HEALTH AUTHORITY (IHA)

The surgical review for the IHA was launched in April 2003. The start of implementation is planned for May 2004. The goal is to improve access to surgical services, improve the quality, effectiveness and efficiency of the surgical program, and define the surgical services role of each acute care services site.

FRASER HEALTH AUTHORITY (FHA)

A redesign plan of acute services was completed in 2002/03. It includes significant work on consolidating services and optimizing use of resources and capacity. Following resolution of its affiliated acute site contract negotiations, the FHA will refresh this plan for 2003/04 and continue implementation. A review of endoscopic surgery was completed in 2002/03. FHA is currently developing scope of practice and networks of care for paediatric surgical care.

VANCOUVER COASTAL HEALTH AUTHORITY (VCHA)

Phase 1 of the *Regional Surgical Services Planning Project* was completed in December 2002. Phase 2 will establish a network of surgical care across VCHA. Implementation is scheduled for 2003/04.

VANCOUVER ISLAND HEALTH AUTHORITY (VIHA)

An inventory of surgical services has been completed. An *Acute Care Core Business Review* will be completed in 2004/05.

NORTHERN HEALTH AUTHORITY (NHA)

In 2002/03, NHA completed the *Prince George Hospital Surgical Services Program Peer Hospital Review*. The review found operational practices were comparable to peer hospitals. Operational system changes to support increased efficiency of surgical services are being planned.

PROVINCIAL HEALTH SERVICES AUTHORITY (PHSA)

PHSA has led the development of a Provincial Thoracic Surgery Program with four regional thoracic surgery centres in the province: one in Vancouver and one in Kelowna (both now fully developed); one in Victoria (expected in late 2003/04); and one in the FHA (now in the planning stage).

Along with the Priority System Improvement Performance Measures, the Ministries also monitored and assessed acute care capacity across BC health authorities.

ACCESS TO ACUTE CARE SERVICES

Several Ministry of Health Services utilization indicators were used to assess access to acute care services. Taken together, these measures provide the checks and balances by which it is possible to determine if patient care and access to services are being appropriately protected. As acute care redesign moves forward, it is expected that:

- inpatient hospital utilization rates will continue to drop in keeping with the trend observed over the past 30 years;
- day surgery and outpatient services will increase to reflect a growing reliance on those services;
- referral patterns and health authority hospital self-sufficiency rates , to determine whether people have access to a wide range of hospital and speciality services within their own regions , will remain relatively stable; and
- access to care will increase through strong management and innovations leading to increased capacity.

The combination of indicators used to assess access for 2002/03 include:

1. Acute/Rehabilitation Care Utilization Rates
2. Acute/Rehabilitation Care Referral Patterns to other health authorities
3. Timely Access to Surgery

Given the interdependent nature of health services, it is important to consider the results within the context that:

- The rate of admission for patients with conditions that can often be treated outside a hospital is decreasing. Two measures or indicators are used to monitor these trends: MNRH (May Not Require Hospitalization) and ACSC (Ambulatory Care Sensitive Conditions).
- The rate per 1000 population for procedures known to affect quality of life, such as hip and knee replacement surgery, are increasing with time.
- Mortality rates have been decreasing throughout the same three decades that inpatient bed use has been decreasing.

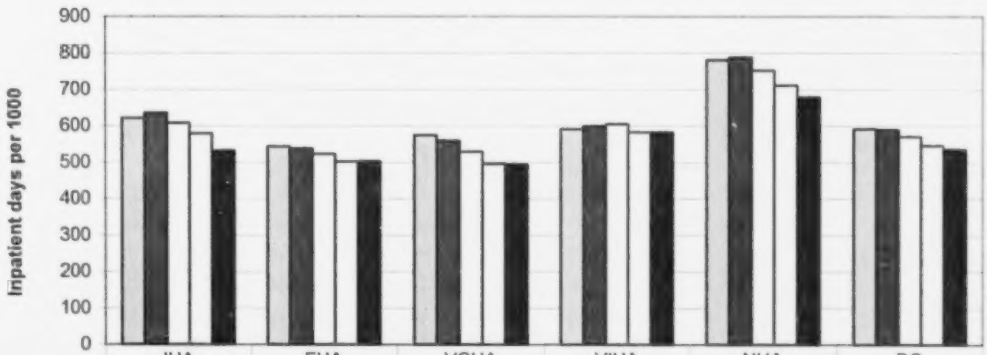
1. ACUTE CARE/REHABILITATION UTILIZATION

a) Acute/Rehabilitation Inpatient Days per 1000 Population
(Discharge Abstract Database [DAD])

Acute care bed use, in hospitals across health authorities, continued to decrease at a rate consistent with previous years. The greatest changes occurred in health authorities with the highest utilization rates in 1998/99 (i.e. rural authorities such as IHA and NHA).

Historically, inpatient utilization rates have been the highest in rural areas. NHA, with proportionately the largest rural population, has the highest use of inpatient services. These rates are in part due to the poorer health status of the population compared to the rest of the province, as evidenced by higher standardized mortality rate (SMR) , a proxy for health status. Higher SMRs are associated with higher utilization rates. However, in general, rural populations have a higher utilization rate than urban populations, even when these differences are taken into account. The higher rate in the NHA may also be due to inefficiencies related to seeing smaller numbers of people over very large geographic areas and/or practice patterns by health care providers.

Acute/Rehabilitation Inpatient Days



	IHA	FHA	VCHA	VIHA	NHA	BC
1998/99	621	543	574	591	780	591
1999/00	635	537	559	599	788	589
2000/01	608	522	528	604	751	570
2001/02	579	502	495	582	711	545
2002/03	532	502	493	582	678	535

Notes:
1. Excludes non-residents, newborns, therapeutic abortions and Riverview Hospital cases with total length of stay > 180 days (Riverview began reporting in 2002/03).
2. Rates are per 1000 population and are standardized using the indirect method and 20 age groups.
3. Data understates the number of out-of-province inpatient hospitalizations of BC residents as data from Alberta are incomplete for 2002/03. There is an estimated 1000 (25%) Alberta inpatient cases missing.

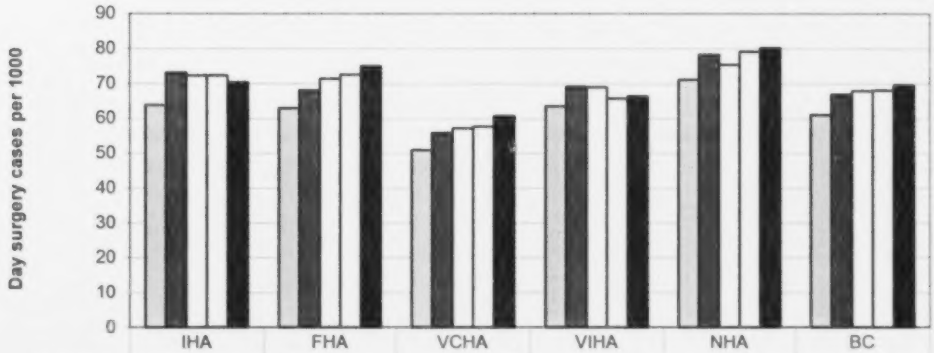
Sources: DAD, September 23, 2003, Information Resource Management, Knowledge Management & Technology Division, BC Ministries of Health (ref # 2003_444); P.E.O.P.L.E. 28, BC Stats, BC Ministry of Management Services; Health Data Warehouse, BC Ministries of Health.

b. Day Surgery Cases per 1000 Population (DAD)

Day surgery rates reflect differing practice patterns and do not reflect the significant amount of surgery being undertaken in ambulatory clinics under local anaesthesia (e.g. breast program).

Over the past five years, day surgery utilization rates have been increasing in all health authorities. For 2002/03, the rates increased from 2001/02 for FHA, VCHA, and NHA; VIHA remained the same, and IHA had a slight decrease.

Day Surgery Cases, 1998/1999 to 2002/03



	IHA	FHA	VCHA	VIHA	NHA	BC
1998/99	64	63	51	63	71	61
1999/00	73	68	56	69	78	67
2000/01	72	71	57	69	75	68
2001/02	72	72	58	66	79	68
2002/03	70	75	61	66	80	69

Notes:
1. Excludes non-residents, newborns, and therapeutic abortions. Riverview Hospital began reporting in 2002/03.
2. Rates are per 1000 population and are standardized using the indirect method and 20 age groups.
3. Data understates the number of out-of-province day surgery hospitalizations of BC residents as data from Alberta are missing for all five years reported. There is an estimated 3000 Alberta day surgery cases missing per year.

Sources: DAD, September 23, 2003, Information Resource Management, Knowledge Management & Technology Division, BC Ministries of Health (ref #2003_544); P.E.O.P.L.E. 28, BC Stats, BC Ministry of Management Services; Health Data Warehouse, BC Ministries of Health.

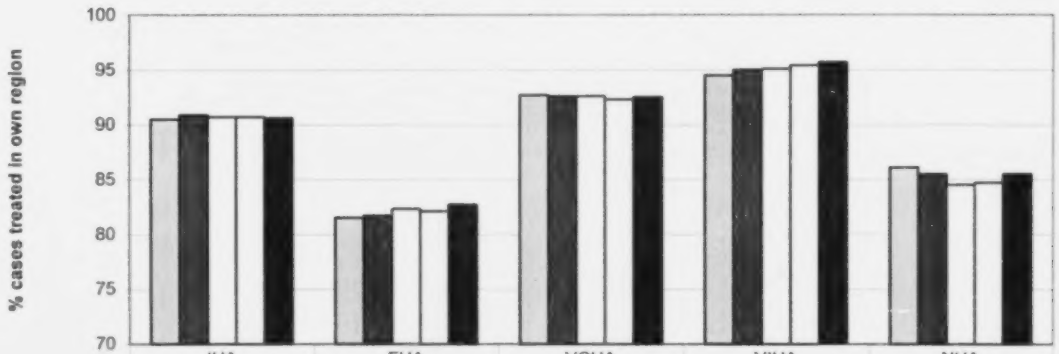
2. ACUTE/REHABILITATION CARE REFERRAL PATTERNS TO OTHER HEALTH AUTHORITIES

a) Inpatient Hospitalization Self-Sufficiency (DAD)

Part of the rationale for establishing five regions lay in their increased ability to be self-sufficient thereby providing the majority of care for their population within their own boundaries. For purposes of comparison, the previous 52 regions have been grouped into the five new regional health authorities.

Access to services within the regions remained relatively stable, with four health authorities showing a slight improvement in their self-sufficiency rates in 2002/03. The relatively low level of self-sufficiency in the FHA relates to its adjacency to VCHA and historical referral patterns between these two, largely urban, regions.

Inpatient Hospitalization,
Health Authority Self-Sufficiency Rates, BC, 1998/99 to 2002/03



	IHA	FHA	VCHA	VIHA	NHA
1998/99	90.5	81.5	92.7	94.5	86.1
1999/00	90.9	81.7	92.6	95	85.5
2000/01	90.7	82.3	92.6	95.1	84.5
2001/02	90.7	82.1	92.3	95.4	84.7
2002/03	90.6	82.7	92.5	95.7	85.5

Notes:
1. Excludes newborns, therapeutic abortions, and Riverview Hospital cases.
2. Data understates the number of out-of-province inpatient hospitalizations of BC residents as data from Alberta are incomplete for 2002/03. There are an estimated 1000 (25%) Alberta inpatient cases missing.

Source: DAD, September 23, 2003, Information Resource Management, Knowledge Management & Technology Division, BC Ministries of Health (ref#2003_315).

3. TIMELY ACCESS TO SURGERY

a) **Number of Surgeries** (DAD) **and Major Procedural Services** (Medical Services Plan [MSP])

The most complete picture of surgical cases performed in BC hospitals comes from the DAD. Province-wide, there were 406,854 inpatient and day care surgical procedures performed in BC hospitals in 2001/02. In 2002/03, there were 415,340 cases, representing a 2.1% increase over the previous year. Four of the five regional health authorities increased the volume of surgical cases in 2002/03, with the FHA exhibiting the largest increase (over 4%).

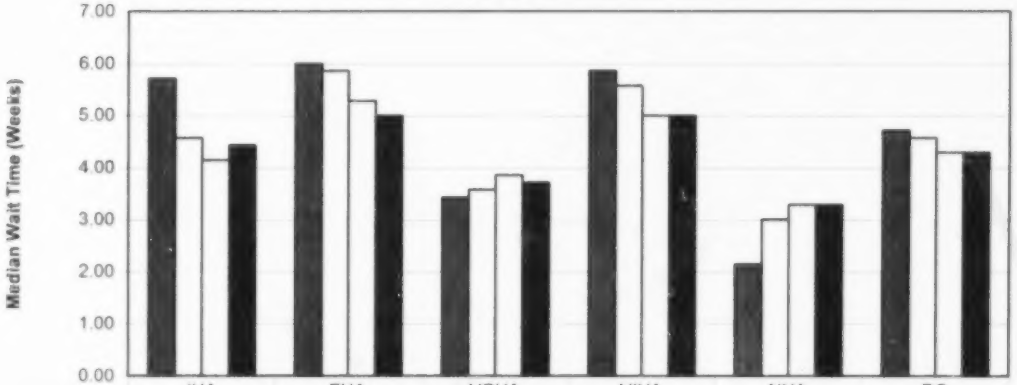
It is also important to examine MSP billing data, which provide the most comprehensive capture of all major procedures. The number of services billed and paid under specific service codes for major services performed in all locations (including physician offices, clinics, outpatient facilities, day surgery suites or full operating rooms) increased by approximately 38,000 from 2001/02 to 2002/03, which is an increase of 4.55%.

b) Median Wait Time for Surgeries (Surgical Waitlist Registry)

The *Provincial Surgical Waitlist Registry* captures information on the majority of scheduled surgical procedures done in most large BC hospitals , and excludes unscheduled cases, such as emergency surgeries. Median wait time is the point at which one half of the clients have had their surgery and the other half are still waiting.

From 2001/02 to 2002/03, median surgical wait times in BC remained stable despite an increase in population. Previous data from 2001/02 to 2002/03 showed an overall increase in surgical activity in the province.

Median Wait Time for Surgeries Completed from the Surgical Waitlist Registry, 1999/2000 to 2002/03



	IHA	FHA	VCHA	VIHA	NHA	BC
1999/00	5.71	6.00	3.43	5.86	2.14	4.71
2000/01	4.57	5.86	3.57	5.57	3.00	4.57
2001/02	4.14	5.29	3.86	5.00	3.29	4.29
2002/03	4.43	5.00	3.71	5.00	3.29	4.29

Notes:
1. Data are based on the best data that is available to date, but may be incomplete.
2. Data do not include cancer services, cardiac surgery, corneal transplants and organ transplants.

Source: SWIFT Closed Bookings, December 1, 2003, Information Resource Management, Knowledge Management and Technology Division, B.C. Ministries of Health (ref. # 2003 –388).

MENTAL HEALTH CARE REFORM

Service Plan Goal:
- High-quality, patient-centred care.

Health Authority Related Service Plan Strategy:
- Modernize the mental health system of care through implementation of the Mental Health Plan.

Performance Agreement Expectations:
- Increase use of needs-based and evidence-based best practices to achieve:
  - Decrease by 4% over three years in Alternate Level of Care (ALC) days spent by mental health and alcohol and drug clients in hospitals once the primary need for inpatient care has been completed.
  - Improved continuity of care measured by a 3% increase in the proportion of persons hospitalized for a mental health diagnosis who receive community or physician follow-up within 30 days of discharge.
- Develop provincial tertiary services and devolve Riverview Hospital.

BC's vision for mental health and addictions reform is the creation of a comprehensive, integrated and evidence-based continuum of services that ranges from support for health promotion efforts to access to timely and appropriate treatment and recovery services. The goals for this system of care are improved mental health of British Columbians as demonstrated through reduced disability, increased resiliency and self-care, and decreased need for health services.

Seeking to improve the health and functional status of people with mental disorders and/or substance use disorders, their families, and the communities in which they live, mental health reform consists of three major initiatives:

- implementing evidence-based best practices;
- supporting health authorities to implement evidence-based, integrated community infrastructure; and
- developing provincial tertiary services.

The Ministries have supported health authority planning and delivery of improved mental health and addictions services with the development and/or distribution of a variety of evidence-based resource manuals, planning guidelines, and best practice publications on a number of topics, including:

- depression and anxiety disorders;
- early psychosis care;
- electro-convulsive therapy;
- mental health care planning for the elderly;
- supporting families with parental mental illness; and
- peer support.

Reflecting best practice recommendations, community and hospital mental health services were integrated at the health authority level, and addictions services and mental health services are being better integrated throughout the system.

In addition, health authority related indicators were established to measure progress toward development of an integrated community infrastructure:

- Appropriate Use of Mental Health Acute Care Services
- Continuity of Care
- Development of Tertiary Mental Health Services

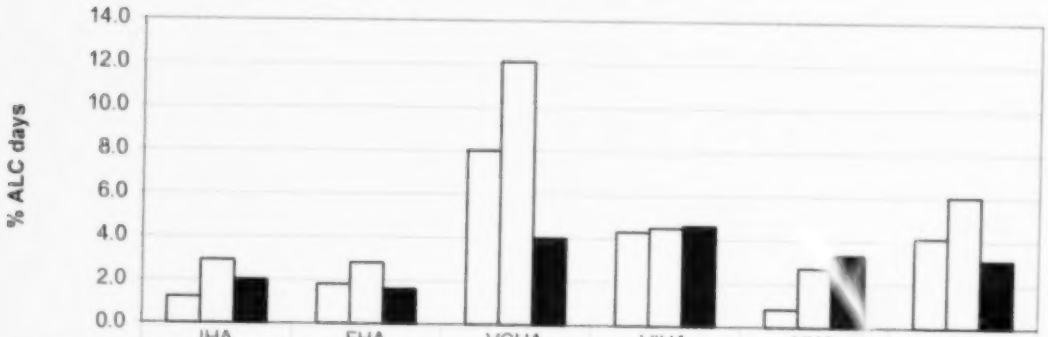
APPROPRIATE USE OF MENTAL HEALTH ACUTE CARE SERVICES

The appropriate use of acute care services by mental health clients in BC is assessed in terms of ALC days as a percent of total inpatient days for patients (aged 15-64) hospitalized for a primary diagnosis of mental illness. Best practices for mental health reform indicate clients experience decreased disability and better health outcomes when the services they receive are matched to their needs. The appropriate use of acute care services is, in part, reflected through a decrease in the use of ALC days by mental health and addiction clients after their need for inpatient care has ended.

On average, over the past five years, mental health clients spent approximately 230,000 inpatient days per year in acute care hospitals in BC. However, once hospital care is no longer required, a percentage of clients remain in hospitals in ALC beds awaiting community placements. Over the past five years, mental health ALC days have increased (from 6,725 in 1998/99 to 13,924 in 2001/02).

2002/03 BC data show a significant decrease from 2001/02 in ALC days as a percent of hospital inpatient mental health days in IHA, FHA, and VCHA. NHA and VIHA are still facing challenges with respect to meeting their targets. However, active planning and changes continue across health authorities and the long-term target may be achieved sooner than expected.

ALC Days as a Percent of Hospital Inpatient Days, Age 15-64, Hospitalized for Mental Health Diagnosis, BC, 2000/01 to 2002/03



	IHA	FHA	VCHA	VIHA	NHA	BC
2000/01	1.2	1.8	8.0	4.3	0.8	4.1
2001/02	2.9	2.8	12.1	4.5	2.7	6.0
2002/03	2.0	1.6	4.0	4.6	3.3	3.1

Notes: Inclusions: Level of Care = Acute/Rehab/ALC/DPU. Most responsible diagnosis: For years up to and including 2000/01: ICD-9 290-314, V61 or V62. For years 2001/02 onward: ICD-10 CA codes for mental health diagnoses as translated from ICD-9 (F00-F53,F 55-F69, F84, F90-F99, G312, G442, R410, Z281, Z55-Z57, Z60-Z65, Z72, Z73). Non-BC residents
Exclusions: BC residents hospitalized out of province, newborns, Riverview Hospital, Therapeutic abortions.

Source: DAD, October 21, 2003, Information Resource Management, Knowledge Management & Technology Division, BC Ministries of Health (ref # 2003_541).

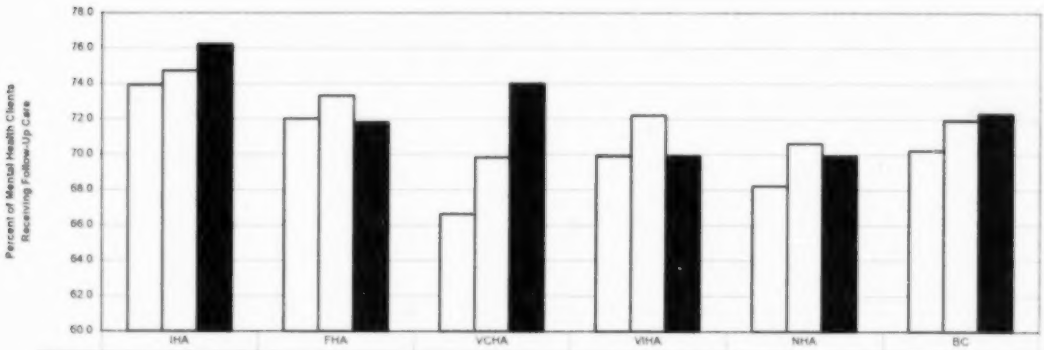
CONTINUITY OF CARE

Continuity in the care of mental health clients who are discharged from acute care hospitals in BC is measured in terms of the follow-up rate by community mental health centres and physicians within 30 days of hospital discharge. Following an acute episode of care, supporting continuity of care is critical. Effective chronic disease management of mental illnesses, including early detection of recurring symptomatology, early intervention, relapse prevention, treatment, and self-management, requires linking clients on discharge from hospital with the community care system to reduce or minimize disability. Thus, continuity of care is measured through an increase in mental health clients receiving community or physician follow-up within 30 days of hospital discharge.

Since 1998/99, the follow-up rate has been fluctuating. For example, in 1998/99 the rate was 70.8% of the patients discharged from acute care facilities; in 1999/2000 it increased to 71.7% and then fell to 70.2% by 2000/01. These variations are, in part, attributable to incomplete community mental health data through the Mental Health Data Warehouse. The Ministries are working with health authorities to increase reporting of community data to improve monitoring of this indicator.

The BC follow-up rate increased by 2.4% in 2001/02 over the 2000/01 base year and increased by 3.0% in 2002/03, relative to the base year of 2000/01. This improvement was not consistent across all health authorities indicating the need for ongoing work in this area.

Percent of Mental Health Clients Receiving Community Follow-up Within 30 Days of Hospital Discharge, 15-64 Age Group, 2000/01 to 2002/03



	IHA	FHA	VCHA	VIHA	NHA	BC
2000/01	73.9	72.0	66.6	69.9	68.2	70.2
2001/02	74.7	73.3	69.8	72.2	70.6	71.9
2002/03	76.2	71.8	74.0	69.9	69.9	72.3

Notes:

1. Includes acute/rehab care levels and BC residents hospitalized out-of-province.
2. Excludes out-of-province residents and Riverview hospital cases with length of stay greater than 180 days.
3. Data understates the number of out-of-province inpatient hospitalizations of BC residents as data from Alberta are incomplete for 2002/03. There is an estimated 1000 (25%) Alberta inpatient cases missing.

Sources: MHR, December 1, 2003; DAD, acute separations to March 31, 2003; CPIM, care episodes to October 27, 2003. MSP fee-for-service database, payments to November 3, 2003; Information Resource Management, Knowledge Management & Technology Division, BC Ministries of Health (ref # 2003_541).

DEVELOPMENT OF TERTIARY MENTAL HEALTH SERVICES

The BC government committed to the redevelopment and enhancement of provincial tertiary services over the next five years, with the intention of enabling British Columbians to access more specialized mental health assessment and treatment in their local communities. Increased capacity within the health authorities will be achieved by the redevelopment and redistribution of 808 Riverview Hospital beds.

In 2002/03, health authorities made substantive progress in developing regional tertiary mental health service capacity. As of March 31, 2003, 83 redevelopment beds were in operation in regional health authorities, including:

- 24 beds at Seven Oaks in Victoria (VIHA);
- 19 beds at Iris House in Prince George (NHA), and
- 40 beds at the South Hills Centre in Kamloops (IHA).

With these beds, IHA and NHA met their redevelopment targets for 2002/03. Although VIHA did not meet the 33 targeted beds for 2002/03, 24 beds (targeted for 2001/02 completion) were opened in 2002/03. The beds targeted for 2002/03 were delayed due to the need for integrated planning, given their new and larger health region.

FHA and VCHA were not targeted to build beds in 2002/03 but have been involved in integrated planning for tertiary redevelopment in future years.

The PHSA is responsible for coordinating the devolvement of Riverview Hospital with regional health authorities. PHSA has achieved significant operational efficiencies at the Riverview Hospital site while positively and successfully supporting patients, families, physicians, and staff in planning for the reform of tertiary services across the province.

HOME AND COMMUNITY CARE REDESIGN

Service Plan Goal:

- High-quality, patient-centred care.

Health Authority Related Service Plan Strategy:

- Reallocate resources and develop policy to support innovative community care, home care, and palliative care services as alternatives to institutional care.

Performance Agreement Expectations:

- Implement the new assessment tool for home care (MDS-HC) by 2004/05.
- Implement the new assessment tool for residential care (MDS V2.0) by 2006/07.
- Increase the proportion of home and community care clients with high care needs (assessed at the IC2 care level or higher) living in their own home, rather than in a facility, by 2%.

The goal of home and community care (HCC) redesign is to increase the capacity of the health system to respond to a full range of needs and preferences as people age or become disabled and rely on health services on a more continuous basis.

This means having a variety of service options available, from residential care facilities for clients with advanced and complex chronic care needs to affordable assisted living residences or home support options for seniors or people with disabilities who want and can live as independently as possible.

Providing both home and residential care clients with appropriate services requires objective, sensitive, standardized, and comprehensive methods for assessing clientsdneeds. Implementation of standardized assessment tools is an important step toward improving the appropriate placement of clients, as well as providing the data needed for accurate care planning, resource allocation, and policy setting.

Increased HCC options also help to relieve pressure on acute care by providing alternatives for people who need care but who dond necessarily need or want hospital care as their only option.

Ensuring acute care beds are available to, and used by, patients who require services of that level of intensity has been a long-standing challenge for hospitals and health authorities.

At any one time, patients who require care, but not acute care, may occupy a substantial number of beds in hospital facilities. Often they cannot be discharged from hospital until alternative services, such as residential care, community-based home care, mental health care or rehabilitation services are available. For this reason, ALC days in acute care hospitals are a measure of both appropriate hospital utilization and ability to respond to clients needs.

As redesign activities in the home and community care sector continue in conjunction with acute care redesign there will be an improvement in:

- Matching HCC Resources with Client Needs
- Opportunities for Home-based Care
- Optimizing Access to Residential Care
- Access to Independent Living
- Reduced Pressure on Acute Care System

Taken together, these activities will ensure client access to appropriate HCC services is available.

MATCHING HCC RESOURCES WITH CLIENT NEEDS

The Ministry, in consultation with health authorities, identified the need for an improved, reliable, and valid assessment tool to replace the current Long Term Care (LTC1) assessment form. An improved client assessment process is reflected through implementation of new assessment tools, resulting in better matching of resources to client needs.

After review, the *InterRAI* home care (MDS-HC) and residential care (MDS V2.0) assessment tools were selected as the new standard for the province. These tools were developed by a group of international researchers and have been tested and implemented in a number of countries. Within Canada, these tools are currently being used in Ontario, Nova Scotia, Saskatchewan, Manitoba, and the Yukon. The standardized, comprehensive *InterRAI* assessment has been demonstrated to provide improved client outcomes and reliable data for monitoring and evaluation of health care resources.

Health authorities are at varying stages of implementation of the MDS-HC and will continue the roll-out of the tool until April 1, 2005, when the MDS-HC will officially replace the LTC1 as the new assessment tool for home care clients. Health authorities have also developed their project plan for the next stage , implementing the MDS V2.0 for residential care clients , to be implemented by April 1, 2007. Implementation of the residential care assessment tool will occur in most health authorities after full implementation of the home care tool has been completed.

OPPORTUNITIES FOR HOME-BASED CARE

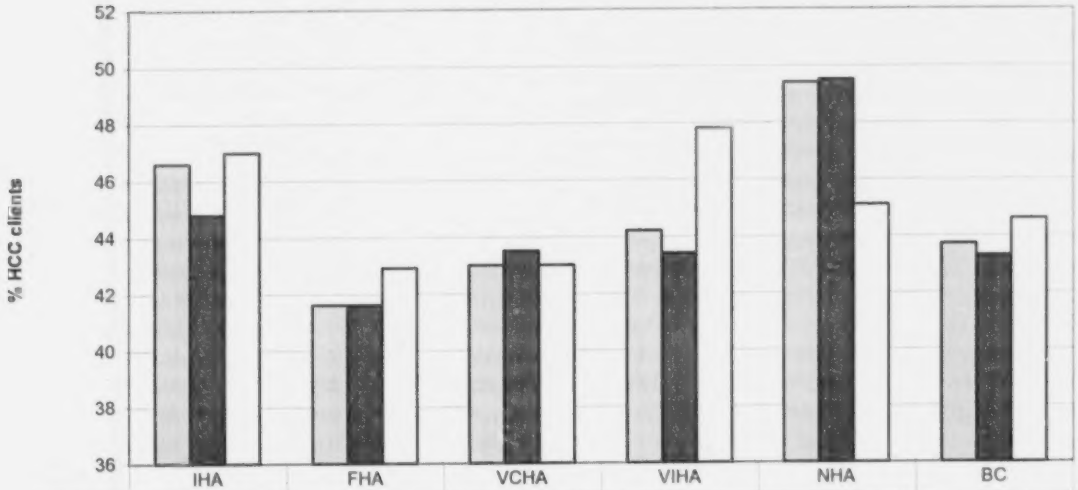
Although there is no standard or benchmark for the percentage of high-care needs clients who should be able to live at home with support rather than in a facility, there is ample evidence an appropriate balance has not yet been reached in BC.

In the late 1990¢s, studies of clients on waitlists and in residential care found a significant number did not require the 24-hour care and supervision available in a facility. A number of factors, including social isolation of the client and a lack of community alternatives, had resulted in more reliance on care facilities in some areas than others. This evidence encouraged health authorities to look at expanded/enhanced HCC services, including assisted living and independent housing, as more appropriate care options for those clients who do not require the higher intensity of services provided in a residential care facility.

As the following table shows, health authorities have made some gains in increasing the percentage of high-care needs clients living in a home setting rather than in a facility. However, in areas where home support service utilization levels were significantly higher than the norm, services provided to clients with lower care needs required adjustment before services to clients with high care needs could be increased.

Three regions (IHA, FHA, and VIHA) had an early start to their service realignment, allowing them to demonstrate results in their redesign strategies in 2002/03 that exceeded the performance target of a 2% increase of home and community care clients with high care needs living at home. NHA and VCHA, on the other hand, include some Health Service Delivery Areas (HSDAs) with historically high utilization rates for home support and residential care compared to others in their authorities. These inequities were being addressed in 2002/03, while at the same time they were preparing for service shifts and enhancements in other HSDAs. As both of these health authorities had their redesign strategies underway by late 2002/03, their efforts should be reflected in the next performance report. Preliminary data for 2003/04 indicates all health authorities are moving towards meeting the shift to more home-based support for higher need clients.

Percent of HCC Clients with High Care Needs Living at Home, BC, 2000/01 to 2002/03



	IHA	FHA	VCHA	VIHA	NHA	BC
2000/01	46.6	41.6	43	44.2	49.4	43.7
2001/02	44.8	41.6	43.5	43.4	49.5	43.3
2002/03	47	42.9	43	47.8	45.1	44.6

% Change from 2001/02 to 2002/03	IHA	FHA	VCHA	VIHA	NHA	BC
	4.8	3.1	-1.3	9.9	-8.9	3.0

Notes:

1. Only clients assessed at IC2, IC3 or EC are included in the report.
2. The location is determined from the provider's postal code.
3. Services authorized by Mental Health are INCLUDED for community care and EXCLUDED for facility care.
4. Data for clients receiving care at home includes Adult Day Care, Home Support, CSIL, and Assisted Living.
5. Data for clients receiving care in a facility includes those in residential facilities, group homes and family care. Respite care is excluded.

Source: CC Data Warehouse, November 28, 2003, Information Resource Management, Knowledge Management & Technology Division, BC Ministries of Health (ref#2003_541).

OPTIMIZING ACCESS TO RESIDENTIAL CARE

Optimized access to residential care by facilitating more appropriate admissions to residential care is measured through admissions by care level as a percentage of total admissions.

Although a provincial assessment tool has been in use in BC for approximately 30 years, it did not include specific standardized criteria to determine real need for residential care. A health care provider could assess a client's functional and cognitive abilities but there were no standardized factors to guide placement decisions. This resulted in significant inappropriate utilization and long chronological waitlists.

In April 2002, a Residential Access Policy was introduced that includes complex care criteria to ensure only those clients who require 24-hour care and supervision are admitted to a facility or given priority access for the next available bed.

There are currently five care levels used to define a client's functional abilities. Personal Care (PC) and Intermediate Care 1 (IC1) are assigned to clients with low-care needs, while Intermediate Care 2 (IC2), Intermediate Care 3 (IC3), and Extended Care (EC) levels indicate increasingly higher care requirements.

Prior to the policy's introduction, admissions of clients assessed at the PC/IC1 levels were negligible, however, clients assessed at the next highest care level (IC2) represented almost one-third (31%) of admissions to residential care. Best practice indicates this group of clients can often have their needs met in a non-institutional setting. The remaining 68% admitted were at the highest care levels (IC3 and EC combined).

This changed dramatically in 2002/03 when the new policy was fully implemented. This policy supported the recommendations from the "Community for Life Report" (1999), including the development of alternative care options to residential care facilities for those clients who required less intensive services. As the table below shows, in 2002/03 only 11% of BC admissions were at the IC2 level, the remaining 88% were admitted at the highest care levels. All health authorities experienced an appropriate decrease in the percentage of IC2 clients being admitted to residential care. The implementation of the new assessment tools, in combination with the residential access policy, will further improve care placement decisions and ensure patients are getting the most appropriate care in the most appropriate setting.

Percentage of Admissions to Residential Care by Care Level

Health Authority	IC2		IC3		EC	
	01/02	02/03	01/02	02/03	01/02	02/03
IHA	29%	10%	42%	54%	27%	35%
FHA	33%	10%	31%	50%	35%	39%
VCHA	28%	8%	37%	51%	34%	39%
VIHA	34%	15%	28%	46%	38%	39%
NHA	38%	25%	30%	46%	30%	27%
BC	**31%**	**11%**	**34%**	**50%**	**34%**	**38%**

Note: Excludes short-stay (less than 31 days) clients.
Source: CC Data Warehouse, May 2003, Information Resource Management, Knowledge Management & Technology Division, BC Ministries of Health.

ACCESS TO INDEPENDENT LIVING

Until recently, most seniors and people with disabilities had only two options when they could no longer live independently: home care or residential care. Assisted living and independent housing , which combine affordable apartments with support services , provide a viable alternative for people who cannot manage safely in their own home, but who do not require 24-hour professional care in a facility.

In partnership with BC Housing, health authorities are responding to the demand for more affordable care options through the Independent Living BC program and by developing additional assisted living and independent housing units on their own. As the table below shows, at the end of fiscal 2002/03, a total of 620 assisted living and independent housing units were opened. These new units represent the progress toward the government's commitment to 3500 new independent living units for the health sector.

Assisted Living and Independent Housing Units, 2001/02 to 2002/03

	IHA	FHA	VCHA	VIHA	NHA	Total
Assisted Living Units Opened Since June 5, 2001	37	99	53	141	117	447
Independent Housing Units Opened Since June 5, 2001	67	84	22	0	0	173
Total	**104**	**183**	**75**	**141**	**117**	**620**

Note: Updated June 2003 by the health authorities.

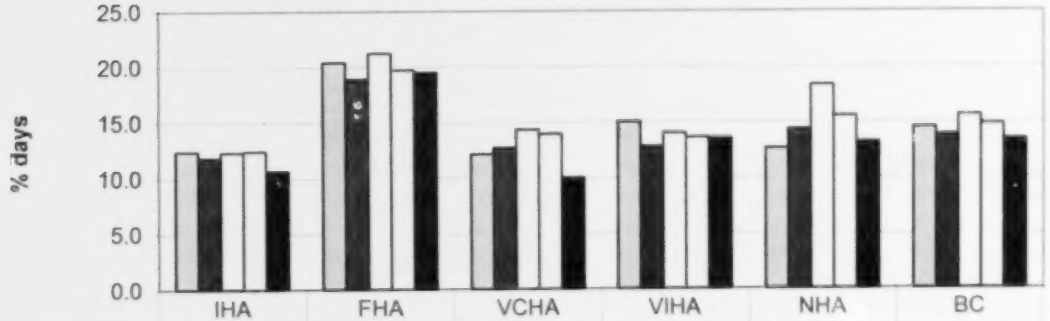
REDUCED PRESSURE ON THE ACUTE CARE SYSTEM

The Ministry of Health Services' Service Plan calls for a decrease in ALC as a percentage of total inpatient days by 5% in each of the three fiscal years from 2002/03 to 2004/05 and 3% in 2005/06. This change should not only result in better use of acute care resources, but also indicates patients are receiving the care they need in the most appropriate setting more quickly.

Keeping reporting issues in mind, the table below shows health authority ALC days as a percentage of inpatient days[3]. In 2002/03, the rates range from 10.0% in VCHA to 19.5% in FHA. The provincial average is 13.4%.

Since 2000/01, all five regional health authorities have shown a decrease in the proportion of hospital inpatient days that are ALC days. Factors contributing to the decrease include the development of transitional or sub acute beds, in some cases within existing residential care facilities, and improved discharge planning. Community care initiatives include realignment of current residential beds within the HSDAs to provide care for more complex clients. In addition, the opening of assisted living and independent housing units and the provision of targeted home support services have also contributed to addressing the resource needs required to support the early discharge of ALC clients from acute care.

ALC Days as a Percent of Total Hospital Inpatient Days



	IHA	FHA	VCHA	VIHA	NHA	BC
1998/99	12.4	20.4	12.1	15.0	12.6	14.5
1999/00	11.8	18.9	12.7	12.8	14.3	13.8
2000/01	12.3	21.2	14.3	14.0	18.3	15.6
2001/02	12.4	19.7	13.9	13.6	15.5	14.8
2002/03	10.6	19.5	10.0	13.5	13.2	13.4

Notes:
1. Includes Level of Care = Acute/Rehab/ALC/DPU, non-BC residents.
2. Excludes newborns, BC residents hospitalized out-of-province, Riverview Hospital, and therapeutic abortions.

Source: DAD, October 21, 2003, Information Resource Management, Knowledge Management & Technology Division, BC Ministries of Health (ref#2003_541).

[3] Intra-provincial comparisons of ALC utilization are difficult to make. Clear definitions for these services, and how they are to be reported, are under development through the auspices of the Canadian Institute for Health Information (CIHI).

PUBLIC/POPULATION HEALTH IMPROVEMENTS

Service Plan Goal:

- Improved health and wellness for British Columbians.

Health Authority Related Service Plan Strategy:

- Reduce occurrence of preventable disease, illness, and disability.

Performance Agreement Expectations:

- Collaborate on the development of core prevention and protection programs based on best practices and performance in other jurisdictions. In 2003/04, consultations to result in list of prioritized core programs for protection and prevention.

DEVELOPMENT OF CORE PREVENTION AND PROTECTION PROGRAMS

In 2002/03, health authorities were required to collaborate with the Ministries of Health and each other in the development of a list ofcore pr ograms for prevention and protection (Public Health Core Functions). Health authorities have participated in this process through their formal representation on a Professional A dvisory Group established to provide input and advice.

Public Health Core Functions will form the legislated, long-term programs that represent the minimum level of public health services health a uthorities will be required to provide. Public Health Core Functions will be part of the new *Public Health Act* and will have clear goals, measurable objectives, and an evidentiary base that shows they can improve or protect peopleÕs health.

The identification and implementation of the Public H ealth Core Functions will help ensure public health capacity within the health authorities remains focused on the most critical areas (i.e. those areas of public health wi th the greatest potential for positive impact).

In the past year, the Public Health Core Functions development process has afforded opportunities for the Ministries of Health, health authorities, and other health partners to collaborate. In October and November 2002, meetings were held with public health staff and others in each health authority to discuss a pre liminary draft of *A Framework for Core Programs and Services in Public Health*. In February 2002, the health authorities and others, meeting as the Professional Advisory Group, provided input and advice to the secon d draft of the Framework.

SUPPORT & ADMINISTRATIVE SERVICES

Service Plan Goal:

- A sustainable, affordable public health system.

Health Authority Related Service Plan Strategy:

- Appropriate organizational capacity to manage the health care system and efficiently delivery necessary services.

Performance Agreement Expectations:

- Each health authority must balance their budgets over 2002/03 and 2003/04, in total, and in 2004/05.
- Health authority equity (including unrestricted funds, internally restricted funds, and investments in capital assets), at the end of fiscal 2004/05, must be equal to or better than their equity as at March 31, 2001.
- Health authorities must reduce the annual expenditures for support and administrative services, by the 2004/05 fiscal year, by at least 7% of the expenditures incurred for the 2001/02 fiscal year.
-

Health authorities are at various stages of redesigning their operations. In terms of support and administrative services, three components were used to assess health authority performance:

- Balanced Budgets
- Equity (overall positive financial position)
- Reduction in Administrative and Support Services Expenditures

BALANCED BUDGETS

As of the 2002/03 fiscal year-end, all health authorities had achieved small surpluses for the year, totaling $95.31 million or 1.6% of the total provincial funding allocation for health authorities. This is a very significant achievementand is the first time in five years that all health authorities in the health sector were successful in balancing their operating budgets. This is a reflection of the strong commitment of the government and the health sector to responsible fiscal management. This surplus will assist health authorities in successfully balancing their budgets over the first two years of health redesign and allow them some flexibility in meeting their three-year performance targets.

The following chart provides a comparison of planned 2002/03 year-end surplus/(deficit) against the actual year-end results as per the audited financial statements for each health authority.

Health Authority	Health Authority Funding Allocation for 2002/03 *(Millions)*	Planned Year-end as per the Budget Management Plan	Year-end position as per the Audited F/S	% of Year-end Surplus of Total Funding Allocation
IHA	$913.9	7.20	49.95	5.5%
FHA	$1,360.2	(17.80)	24.15	1.8%
VCHA*	$1,661.2	(18.90)	2.47	0.1%
VIHA	$988.0	0.10	0.70	0.1%
NHA	$317.1	4.50	3.80	1.2%
PHSA	$818.6	3.70	14.24	1.4%
BC	**$6,059.0**	**(21.2)**	**95.31**	**1.6%**

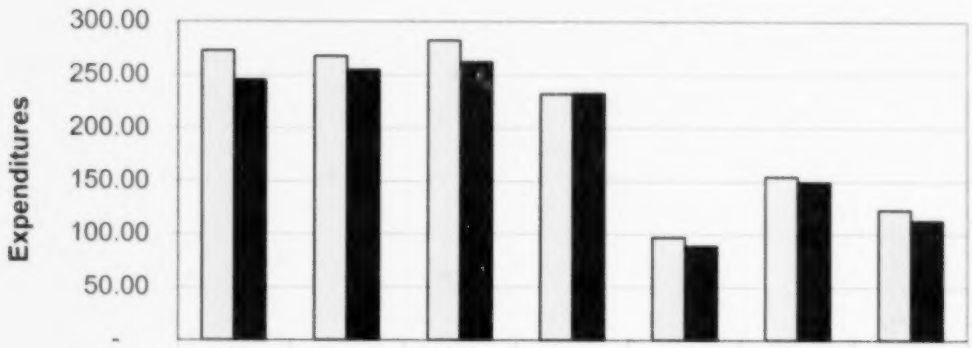
Note: *VCHA includes Providence Health Care.
Source: Ministry of Health Funding Allocation, Budget Management Plan, Audited Financial Statements, June 2003, Finance and Decision Support, BC Ministry of Health Services.

Despite better than expected financial results for fiscal 2002/03, health authorities still face significant challenges in meeting their financial performance targets. For example, unexpected cost pressures, such as the recent unexpectedly high cost-of-living (COLA) increase, continue to challenge their ability to submit balanced budgets. While health authorities had incorporated a COLA increase of 1.5% in their budget plans, the actual COLA lift was 3.2%; more than double what they had budgeted, accounting for a $72 million unanticipated cost pressure.

REDUCTION IN ADMINISTRATIVE AND SUPPORT SERVICE EXPENDITURES

Health authorities are generally making good progress in reducing administrative and support expenditures. These initiatives will be critical in helping health authorities to ensure their resources are directed as much as possible to meet the needs of patients. While VIHA had a minor increase in expenditures in 2002/03, it is expected many of the initiatives that commence in 2003/04 will help them achieve their three-year 7% reduction.

Administration & Support Expenditures by Health Authority (in millions)



	IHA	FHA	VCHA	VIHA	NHA	PHSA	Affiliates
☐2001/02	272.66	267.53	282.05	232.13	96.66	154.00	122.47
■2002/03	245.13	254.56	262.04	232.56	88.57	148.85	112.64

%	IHA	FHA	VCHA	VIHA	NHA	PHSA	Affiliates
Change	-10.1%	-4.8%	-7.1%	0.2%	-8.4%	-3.3	-8.0%

Notes:

1. The PHSA figures may not be complete due to the absence of the corporate entity data.
2. Denominational Affiliates are shown for demonstration purposes only. Affiliates are not currently required to enter into Performance Agreements with MOHS and therefore do not have Administration and Support expenditure reduction targets.
3. A&S expenditure data for 2002/03 for two denominational affiliates, R.W. Large and Bella Coola, have not been received by MOHS.

Source: Health Authority Management Information System (HAMIS), December 04, 2003, Information Resource Management, Knowledge Management &Technology Division, BC Ministries of Health (ref # 2003_541).

CONCLUSION

As noted in the Introduction of this report, articulating clear goals and objectives to be achieved within specified timeframes , and measuring the progress of responsible agencies in reaching those benchmarks , represents a new approach toward ensuring transparent accountability in the management and delivery of health services.

The 2002/03 inaugural Performance Agreements reflect the priority areas for improvement within the health system as a whole, and begin to set the long-term measures that will be used to mark progress in creating a coherent, patient-centred, sustainable public care system.

In a sector as subject to change as health care though, that progress will not always be linear. BC's health care system will continue to evolve in diverse ways as demographics change, technological advancements offer new service options, and new health care challenges emerge.

Early in 2003, for example, BC's health care system was faced with the challenge of responding to a disease that had a profound effect on several countries in the world even before it had a name. The resources required to both successfully contain the spread of Severe Acute Respiratory Syndrome (SARS) in this province and map the genome that will be key to an international understanding and future response to the disease were considerable, largely unforeseen, and critical to the ongoing protection of public health and safety.

As part of BC's service industry, the health care system is also heavily dependent on both professional and non-professional care providers for its success. The changing nature of these relationships, often involving negotiations, contractual arrangements or service protocols, can have a significant impact on the ability to manage delivery of services for our public with our available resources from year to year.

Finally, changes in policy direction, such as those agreed to in the First Ministers Accord calling for an increased focus on home care and primary health care renewal, can also shift funding priorities and further challenge the health care system to meet identified service needs in a timely and comprehensive manner.

2002/03 represents the first full year of operation for BC's new health authorities. In a single year they have assumed significant responsibility for the full continuum of patient services and outcomes, as well as accountable fiscal management. Across the spectrum of health care, an unprecedented level of coordination and cooperation has been achieved, allowing for immediate mobilization among care providers when threats to public health emerge. This report reflects only a portion of the very significant and comprehensive work heath authorities have accomplished while creating a strong foundation for fundamental improvements in our health care system. Change of this magnitude is both difficult and complex and it can take time to fully realize positive results. For this reason, Performance Agreements, like Ministry Service Plans, have been structured as three-year documents. With each successive year, this report will be able to speak more definitively on emerging trends and long-term results.

In the meantime, work on refining expectations for health authority performance continues. Informed by the recommendations of BC Auditor General (May 2003) the Ministries and health authorities have been working collaboratively to ensure the Performance Agreements, and the reports on them, emerge as strong accountability tools that allow British Columbians to assess, and be confident in, the good governance and proper management of their health care dollars and health care services.